Integrating Physical and Behavioral Health Care

CASE STUDY

Behavioral Health Integration Improves Total Cost of Care at University of Rochester Medical Center

Drops in hospitalizations, reduced total cost of care and better patient depression and anxiety scores result from two evidence-based models.

Background

New York-based University of Rochester Medical Center (URMC) is an academic medical center focused on health research, teaching and patient care. URMC has more than 26,000 employees, which makes it the largest component of the University of Rochester, the largest private sector employer based in New York State.

Like the rest of the United States, upstate New York has seen an influx of psychiatric and substance use disorders even before the COVID pandemic, which exacerbated the trend. As demand for behavioral health services continued to grow across URMC's sites and patient population, primary care providers and specialists felt the impact.

In response, URMC psychiatrist George Nasra, M.D., and colleagues asked URMC leadership to invest in models to integrate primary and behavioral health. With the health system's support, Nasra and colleagues launched the Division of Collaborative Care and Wellness. Between 2016 and 2018, URMC integrated behavioral health services in 12 in-house and locally affiliated primary care practices. Since then, the division's reach and impact have expanded, improving patient outcomes and experience, reducing total cost of care and improving workforce satisfaction.

URMC's Approach

URMC uses two major frameworks to guide its integration efforts: the Collaborative Care Model (CoCM) and the Primary Care Behavioral (or Behaviorist) Health (PCBH) model. Both are evidence-based primary care integrated models recognized by the Center for Medicare and Medicaid Services (CMS).

CoCM takes its framework from chronic care management. With CoCM, services are provided by a team including a primary care provider, a co-located care manager with behavioral health training and a psychiatrist (who is not required to be co-located). The model supports patients in a primary care practice who are diagnosed with mild to moderate mental health concerns. Under this model, a primary care physician screens and diagnoses patients and URMC provides ongoing mental health treatment and support. Psychiatric consults are available to the care team for support in diagnosis and treatment determinations, but the psychiatrist does not have direct contact with the patient.

PCBH incorporates a co-located licensed behavioral health provider (psychologist, clinical social worker or counselor) into the primary care team. This allows for the management of a wider range of mental health and substance use concerns. PCBH

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includes evidence-based screenings, warm handoffs for behavioral health treatment, evidence-based treatments and time-limited therapy. If patients' needs are not fully met, URM refers them to additional care.

Between 2016 and 2018, URMC implemented PCBH in six of its primary care practices and beginning in 2019, instituted the CoCM model across an additional six university-employed and -affiliated community practices. Nasra credits part of the programs' success to internal liaisons who collected metrics, redesigned workflows and otherwise communicated with URMC's Department of Psychiatry.

While much of the department has largely focused on integrating behavioral health care into primary and outpatient practices, URMC leaders — with the help of HRSA grant funding — embedded social workers in three local affiliated emergency departments to help triage and manage patients' behavioral health concerns. Nasra's team provides psychiatric consultation support for these social workers and will evaluate patients remotely when needed.

Impact

Initially, funding for integrated behavioral health models was sourced through grants and available dollars in URMC's system budget. Medicaid and Medicare reimbursement for behavioral health services eventually followed, along with support from New York's DSRIP initiative. Nasra hired in 2018 a health economist to analyze the models' costs and savings.

While anecdotal feedback was positive, sustainable funding efforts required a stronger justification of the model's return on investment. Looking across the URMC footprint and integrated team is key to assessing costs and ROI, Nasra says. Behavioral health provider expenses alone would always show a loss, but do not capture the total care savings.

While evaluation at URMC is still underway, Nasra reports general decreases in hospitalization, reduction in total cost of care and improvement in patient depression and anxiety scores. A 2022 study of PCBH implementation at URMC shows that for nearly 7,000 adults with at least one behavioral health diagnosis, rates of all-cause emergency department visits decreased by 14.2% after PCBH implementation. Additionally, patients tend to see their therapists more, relieving the burden on primary care doctors. This can lead to a reduction in provider fatigue and burnout, Nasra says. Primary care provider visits decreased by 12%, according to the study, while rates of behavioral health provider visits increased by 7.5%[1].

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Next Steps

With more than 45 primary care practices in the URMC system, Nasra wants to expand the program to five more practices within the next year. "Our vision is to offer this model to all practices that are willing to do it," Nasra said. DSRIP funding that supported early implementation efforts is no longer available, but New York's Medicaid program is currently in discussions with CMS for a new federal investment that will support initiatives in delivering value-based care for Medicaid members through models like the ones underway at URMC.

1 Maeng DD, Poleshuck E, Rosenberg T, Kulak A, Mahoney T, Nasra G, Lee HB, Li Y. Primary Care Behavioral Health Integration and Care Utilization: Implications for Patient Outcome an

While the model requires at least one behavioral health clinician per practice, Nasra and his colleagues are exploring innovative strategies to scale the approach. Hiring providers to provide teletherapy is one such option and would allow each behavioral health provider to span two or three practices. URMC is also considering potential vendor collaboration to integrate this model at scale. Concert Health, for example, is a behavioral health group deploying the CoCM model virtually and supports hospitals and health systems expand its access.

While CoCM and PCBH are the predominant models underway at URMC, the Division of Collaborative Care and Wellness has additional initiatives in process. This includes integration with specialty practices including obstetrics and gynecology, URMC's sleep center, transplant program, cardiac, oncology and neurology practices. New ideas are constant — Nasra and his colleagues are also in conversations with URMC's dermatology practice and newly launched Spinal Cord Injury Center to identify opportunities for partnerships.

Word of mouth has contributed successfully to the interest and expansion of integrated behavioral health efforts. "Physicians come knocking on our door, and say, 'hey, George, we want your help to integrate behavioral health,'" Nasra said. "They are recognizing the value."

CONTACT

George Nasra, M.D., M.B.A.
Professor of Clinical Psychiatry, University of Rochester Medical Center
Chief, Division of Collaborative Care and Wellness
Medical Director for Behavioral, Accountable Health Partners
George_Nasra@urmc.rochester.edu